



Children's Mental Health Waiver

ISP Review Criteria for Plan Approval

Individual Service Plan Accompanying Documents

<input checked="" type="checkbox"/>	Reports/Forms/Documents	First ISP	Subsequent quarterly ISPs
	Choice of Provider Form (WP-10)	Required	Submit w/change
	Written legal documentation for legal representative if <u>not</u> parent	Required	Submit w/change
	Psychotropic Medication Consent forms (FCC-6)	N/A	Submit w/new medications
	Family Care Team member evaluations (Mental Health Provider, School, DFS, etc.) (FCT-5)	Required	As requested by Care Team or identified need of youth/family
	Youth Health/Safety Assessment (FCC-5)	Required	As requested by Care Team or identified need of youth/family
	Family Assessment (FCC-4)	Required	As requested by Care Team or identified need of youth/family
	Exceptional Service Plan Request (WP-4)	Required for any ISP cost > \$14,000	
	Treatment Objective forms for all outcome objectives (FCT-1)	N/A	Required for initial ISP
	LOC Re-certification form (WP-3)	N/A	annually
	CASII scoring sheet and instrument	N/A	annually

Demographics Information

- ☐ All fields contain complete information requested – no blanks (N/A may be marked as applicable).
- ☐ **LOC Evaluation / Re-evaluation completed within 45 days of identified ISP start date**
CASII score provided must match most recent screening data and scored within acceptable range (20-27)
- ☐ Plan start and end dates must be within 180 days and no more than 1 day from previous plan date
Example: Initial ISP start date = 7/29/09 End Date = no later than 1/25/10
Bi-Annual ISP start date = 1/26/10 End Date = no later than 07/25/10

Medical Information

<input checked="" type="checkbox"/>	Review Criteria
	Diagnoses match service application for initial ISP Any changes are noted as such in subsequent ISPs
	ALL medications taken by child/youth are listed All fields contain complete information requested – no blanks
	If informed consent marked "Yes" – consent forms should accompany ISP document If marked "No" – plan to obtain must be outlined with target date for completion

Assessments/Evaluations

<input checked="" type="checkbox"/>	Review Criteria
	Assessments reviewed should match reports submitted with ISP For Initial ISP – if no psychological evaluation was available with service application, Team must discuss need and identify specific areas of focus. ↳ Plan should reflect responsible person and time line for scheduling appointment etc. to obtain evaluation.
	If assessment needs are identified for the current plan period, plan should reflect responsible person and time line for scheduling appointment etc.

Family Vision

<input checked="" type="checkbox"/>	Review Criteria
	Stated in a way that can be visualized with specific enough information to allow the Family Care Team to focus their work toward that vision.

Life Domains

<input checked="" type="checkbox"/>	Review Criteria
	General description of child/family's current situation documented under each domain (in the Domain column). Strengths/preferences and wants/needs listed relate to the domain. Strengths/preferences listed can be used to obtain the wants/needs listed. Wants and needs are listed as "needs" statements. All fields contain complete information requested or marked N/A as appropriate.
	Team Plan must demonstrate consideration of family strengths and preferences and show collaboration between Family Care Team members as well as including youth/family and their supports.
	Any domains not addressed must be marked N/A and supported by assessment/evaluation data.
	<i>180 Day Plans</i> – Monitor for level of consistency with previous plan(s) unless significant changes have occurred to justify major changes (must be clearly identified and explained).

Outcome Objectives

<input checked="" type="checkbox"/>	Review Criteria
	Objectives should be stated in measurable terms.
	Information to complete columns of table should be numbered or somehow identified to connect related items across all columns. Information provided should be specific enough to know what needs to be done, the target completion date, the responsible person and type of support this individual represents, the duration/frequency of the service and how the service will be measured/monitored.
	Start date for service implementation is identified.
	Projected date for completion of outcome objective is noted.
	Updates are provided for subsequent quarterly plans until outcome objective is completed or discontinued. If discontinued, reason for action must be documented.

Behavior Support Plan

<input checked="" type="checkbox"/>	Review Criteria
	Completed Behavior Support Plan Document (FCT-6) is attached to/included with ISP document.
	Brief description of what the behavior support plan is, the anticipated benefits, and why it is necessary is documented.
	If no Behavior Support Plan is completed for the ISP, Team rationale for why not or the Team's plan to develop a Support Plan must be documented. If Team's plan is to develop a Behavior Support Plan – expected date to implement plan must be identified.
	Updates are provided for subsequent plans until outcome is met or plan is discontinued. Updates should include number of time support plan was used, its success, what changes were made and why, and any report of new behaviors being identified – both positive and negative. If discontinued, reason for action must be documented.

Team Meeting Minutes

- ☐ Summary of meeting discussions and conclusions and any assignments given not documented elsewhere in the plan – these should include responsible person and expected date of completion.

Plan Development Team

- ☐ All columns of the table are completed for each individual listed on the Family Care Team or marked N/A.
- ☐ Team members who will receive a copy of the approved ISP documented are noted in the last column (bold, X or delete the NO.)
- ☐ Updates to Team composition are made to reflect current Team involved in development of the ISP.

Pre-Approval for Children's Mental Health Waiver Services form

<input checked="" type="checkbox"/>	Review Criteria
	Information requested at the top of the form is complete and correct – no blanks.
	Provider names and numbers for each waiver services to be utilized are noted and correct.
	Units for each service are calculated for the 180 day period of the plan. Family Care Coordinator units should take into account the work done on the initial ISP from the date when services start (date when the Choice of Providers form is signed) to the end of that 180 day period.
	Total cost calculations and total cost for waiver care are correct.
	Signatures and dates of signatures for both Parent/Guardian/Responsible person and Family Care Coordinator are noted.

Medicaid Services to be provided to support the Waiver Plan

- ☐ Mental Health Service(s) and related costs are identified and accurately calculated (units and total costs).
- ☐ Anticipated Medical Services and related costs are identified and accurately calculated based on the payment history provided by the child/youth and family.

ISP Summary Page (last page of ISP document)

<input checked="" type="checkbox"/>	Review Criteria
	"A" total is same as Pre-Approval for Children's Mental Health Waiver Services page total.
	"B" total is same as mental health services identified from previous page (first table).
	If the A + B total is greater than \$14,000 – the Team is required to submit an Exceptional Service Plan Request (WP-4 form) with the ISP document.
	The five statements listed on this page must be initialed by the youth (if 18 or older) or legally responsible person.
	Signatures and dates of signatures for both the Youth or Legally Responsible person and Family Care Coordinator are noted.